

**441—92.4 (249A,249J) Application processing.** Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

**92.4(1) Verification.** Applicants seeking eligibility under 92.2(1) “b” shall provide verification of medical expenses as required under 92.5(5) “b.” IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

*a.* The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

*b.* Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

*c.* If benefits are denied or canceled for failure to provide information and the information is provided within 14 calendar days of the effective date of the denial or cancellation, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information.

**92.4(2) Screening for full Medicaid.** The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

**92.4(3) Time limit for decision.** The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

*a.* One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

*b.* The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).